

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11343 CERTIFICATE OF DEATH

11339

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 1 hr., 5 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin Rea Baby		Middle Beyer, Jr.	4. DATE OF DEATH October 24, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Russell Beaver		14. MOTHER'S MAIDEN NAME Opal Edna Fite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT R. H. Reaver
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (8 months gestation)</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abruption Placenta (molar)</u> DUE TO (c) <u>Hydrocephalus</u>		INTERVAL BETWEEN ONSET AND DEATH 65 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-14</u> , 19 <u>58</u> , to <u>10-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>58</u> , and that death occurred at <u>10-24</u> , 19 <u>58</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED M.D. <u>58 2-1 St Oakland, Md 10-27-58</u>	
ACTUAL SIGNATURE <u>James H. Feaster</u>		PHYSICIAN'S NAME (Type) James H. Feaster	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial 10/25/58		22b. DATE THEREOF 10/25/58	22c. NAME OF CEMETERY OR CREMATORIUM Red Rock Cemetery, near Rowlesburg, West Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. R. Watson</u>		ADDRESS Terra Alta, West Virginia	24a. REC'D BY REGISTRAR DATE OCT 27 '58
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Keane</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11344

## CERTIFICATE OF DEATH

11340

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b		b. COUNTY <b>GARRETT</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>RUTH</b>	Middle <b>AURELLA</b>	Last <b>BITTINGER</b>	4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>30</b> Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/1910</b>	9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSES' AID</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN M. MILLER</b>			14. MOTHER'S MAIDEN NAME <b>DELLA MAE FRIEND</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>260X</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HERBERT BITTINGER</b> Address <b>OAKLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertension</b> 6 yrs (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260X Diabetes Mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) p. m. 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 3rd, 1946</b> , to <b>OCT. 30th, 1958</b> , that I last saw the deceased alive on <b>OCT. 30th, 1958</b> , and that death occurred at <b>9:25 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>E. IRVING BAUMGARTNER, M.D.</b> ADDRESS (Street, city or town, state) <b>25 Allen St., Oakland, Md.</b> DATE SIGNED <b>10/31/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-2-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Luthern Cem.</b>	22d. LOCATION (City, town, or county) <b>Accident, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald J. Marchi, Oakland, Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>NOV 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knau</b>

CERTIFICATE OF DEATH

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11341

Reg. Dist. No.

**11345**

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kempton</b> Oakland		c. LENGTH OF STAY IN lb <b>12 lbs. 25 yrs.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>1 Mi. East of Kempton</b>				
3. NAME OF DECEASED (Type or print)	First <b>Nick</b>	Middle <b></b>	Last <b>Cook</b>			
4. DATE OF DEATH <b>October 31,</b>	Month <b>October</b>	Day <b>31</b>	Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1878</b>			
			9. AGE (In years from birthday) <b>80</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>				
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Nicholas Cook</b>		14. MOTHER'S MAIDEN NAME <b>Angela</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-2919</b>				
17. INFORMANT <b>Tony Cook</b>		Address <b>Davis, W. Va.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>912.1</b> DUE TO <b>Intercranial Hemorrhage, massive</b> INTERVAL BETWEEN ONSET AND DEATH <b>21 hrs.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured skull</b> 21 hrs.						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by log-loading tongs</b>				
20c. TIME OF INJURY Hour <b>3:20</b>	Month, Day, Year <b>p.m. 10-31-58 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	20f. (City or town) <b>Rural Kempton</b>	(County) <b>Garrett, Md.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE <i>James H. Fenster Jr.</i>				DATE SIGNED <b>10-31-58</b>		
EXAMINER'S NAME (Type) <b>James H. Fenster, Jr., M. D. (Acting)</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, <b>Burial</b>		22b. DATE THEREOF <b>11/3/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>East Oak Grove</b>		22d. LOCATION (City, town, or county) <b>Morgantown, W. Va.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.C. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 3 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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HABEN WO STADTWERK WESERGAS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11342

## 11346 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Oakland 6 weeks		b. COUNTY		Garrett		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Evans Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		
3. NAME OF DECEASED (Type or print)		First John	Middle F.	Last Enrbar	4. DATE OF DEATH	Month October	Day 4	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male		White WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	July 3, 1886	72 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired electrical foreman-C&P R. R.				Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Martin Ehrbar		Sophia Fries						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		712-14-1603		Ralph C. Enrbar		Cumberland, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CEREBRAL ARTERIOSCLEROSIS						
334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.								
{ (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
19								
21. I certify that I attended the deceased from 8/22/58, 19, to 10/24/58, 19, that I last saw the deceased alive on 9/19/58, 19, and that death occurred at M, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED 10/5/58
ACTUAL SIGNATURE <i>E.P. Baumgartner</i>		M.D. 25 ALDEN ST						
PHYSICIAN'S NAME (Type) E.P. BAUMGARTNER		OAKLAND - MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/58		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Poggie  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by you, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Film 234 10-17-58 items 10, 11, 13, 14, 15 Film G234 10-14-58 et

11343

Reg. Dist. No.

11347

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>Preston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingwood</b>		85 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home,</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Harold</b>		First <b>Harold</b>	Middle <b>Hollis</b>	Last <b></b>	4. DATE OF DEATH <b>October</b>	Month <b>2</b>	Doy <b>19</b>	Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1915</b>	9. AGE (in years from last birthday) <b>40 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian (Court House)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Crellin, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>Arthur F. Hollis</b>			14. MOTHER'S MAIDEN NAME <b>Eva Frazee</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Navy</b>		16. SOCIAL SECURITY NO. <b>W.W.II</b>		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <b>Bronchopneumonia</b> <b>Arthritis - septicemic</b> <b>Parkinson's Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 years</b> <b>5 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>491X Primary cause: Cirrhosis of the Liver</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Oakland</b>		(County) <b>Preston</b>	(State) <b>W Va</b>
21. I certify that I attended the deceased from <b>8/13/1955</b> to <b>10/21/1958</b> , that I last saw the deceased alive on <b>10/1/1958</b> , and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>A.E. Manee</b>		M.D.		ADDRESS (Street, city or town, state) <b>Oakland, Md</b>					DATE SIGNED <b>20 Oct 58</b>
PHYSICIAN'S NAME (Type) <b>A.E. Manee</b>		161 Third Street, Oakland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 3 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Eglen Cemetery</b>		22d. LOCATION (City, town, or county) <b>Eglen</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur E. Kingwood W Va</b>		ADDRESS <b>161 Kingwood W Va</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kingwood</b>			

CERTIFICATE OF DATA

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

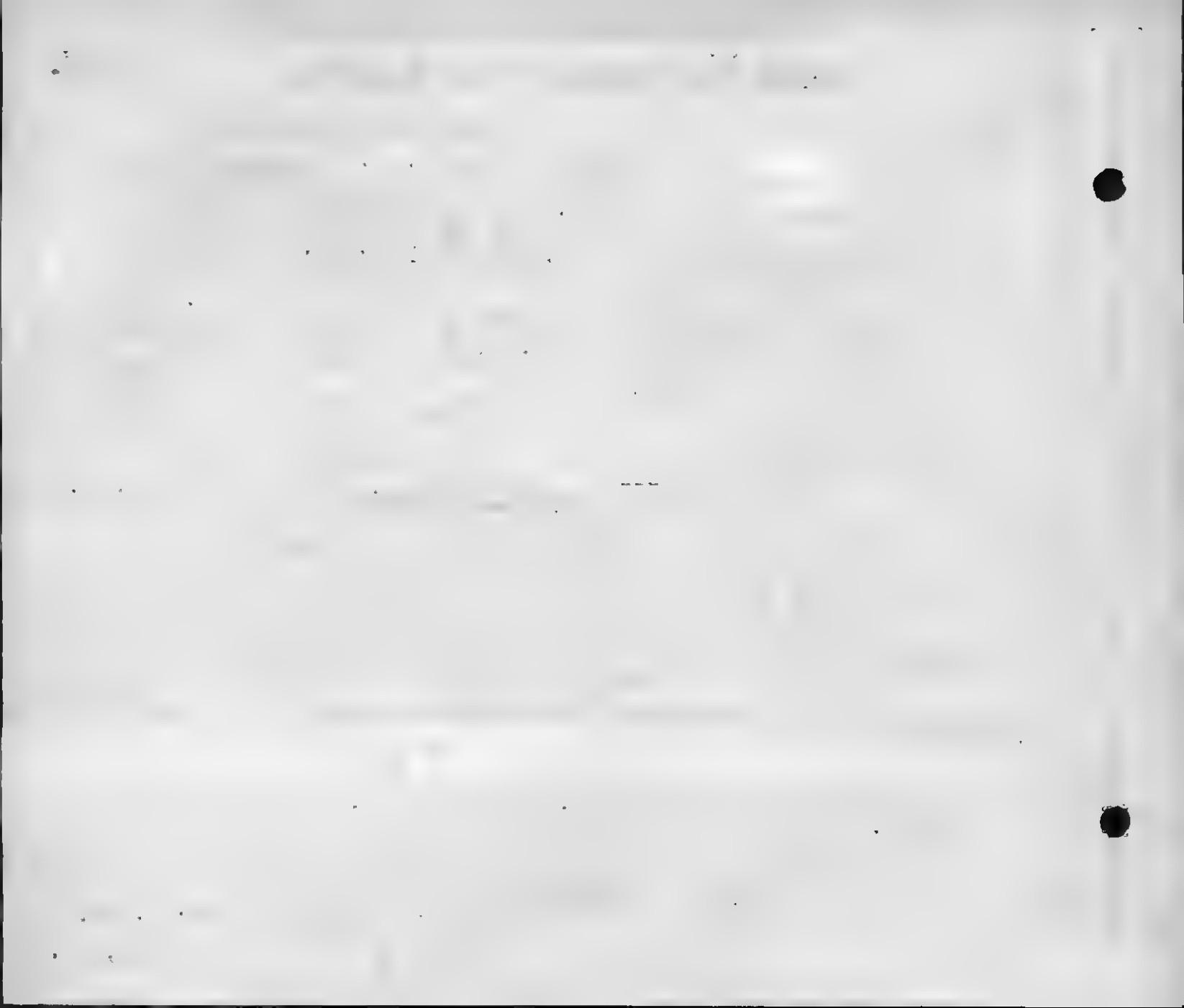
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11348 CERTIFICATE OF DEATH

11344

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
CITY OR TOWN		GARRETT		MARYLAND		STATE W. VA.	
(If outside corporate limits, write RURAL and give nearest town)				LENGTH OF STAY (in this place)		COUNTY GRANT	
CITY OR TOWN		OAKLAND		16 HRS.		CITY OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				ELK GARDEN RURAL			
/ / GARRETT COUNTY MEMORIAL HOSPT.				(If rural give location) 6 Mi. So. Elk Garden			
<b>3. NAME OF DECEASED (Type or Print)</b>				<b>4. DATE OF DEATH</b>			
(First) LOIS (Middle) ETHEL (Last) JONES				OCT. 13 19 58			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
FEMALE	WHITE	MARRIED	OCT. 24, 1918	39 yrs.	Months	Days	Hours Min
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				11. BIRTHPLACE (State or foreign country) WEST VIRGINIA			
13. FATHER'S NAME KEPLINGER, JEFF				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) NO (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. - - -			
17. INFORMANT & ADDRESS ALVIN J. JONES, ELK GARDEN, W. VA.				14. MOTHER'S MAIDEN NAME CLARK, EVELYN			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
4500 IMMEDIATE CAUSE (A) <i>Disseminated Lupus</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
<b>22. I hereby certify that I attended the deceased from Mar. 8th, 19 56, to Oct. 13th, 19 58, that I last saw the deceased alive on Oct. 13th, 19 58, and that death occurred at 11:25 PM, from the causes and on the date stated above.</b>							
SIGNATURE <i>a s. Manee</i> ADDRESS (Street, city, town, state) <i>Oakland May 14 1958</i> DATE SIGNED <i>1400518</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/16/1958		NAME OF CEMETERY OR CREMATORIUM Maysville Cemetery		LOCATION (City, town, or county) Grant County, W. Va. (State)	
24. REC'D BY REGISTRAR DATE OCT 17 1958		REGISTRAR'S SIGNATURE <i>Arthur S. Traud</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>		ADDRESS Oakland, Md.	

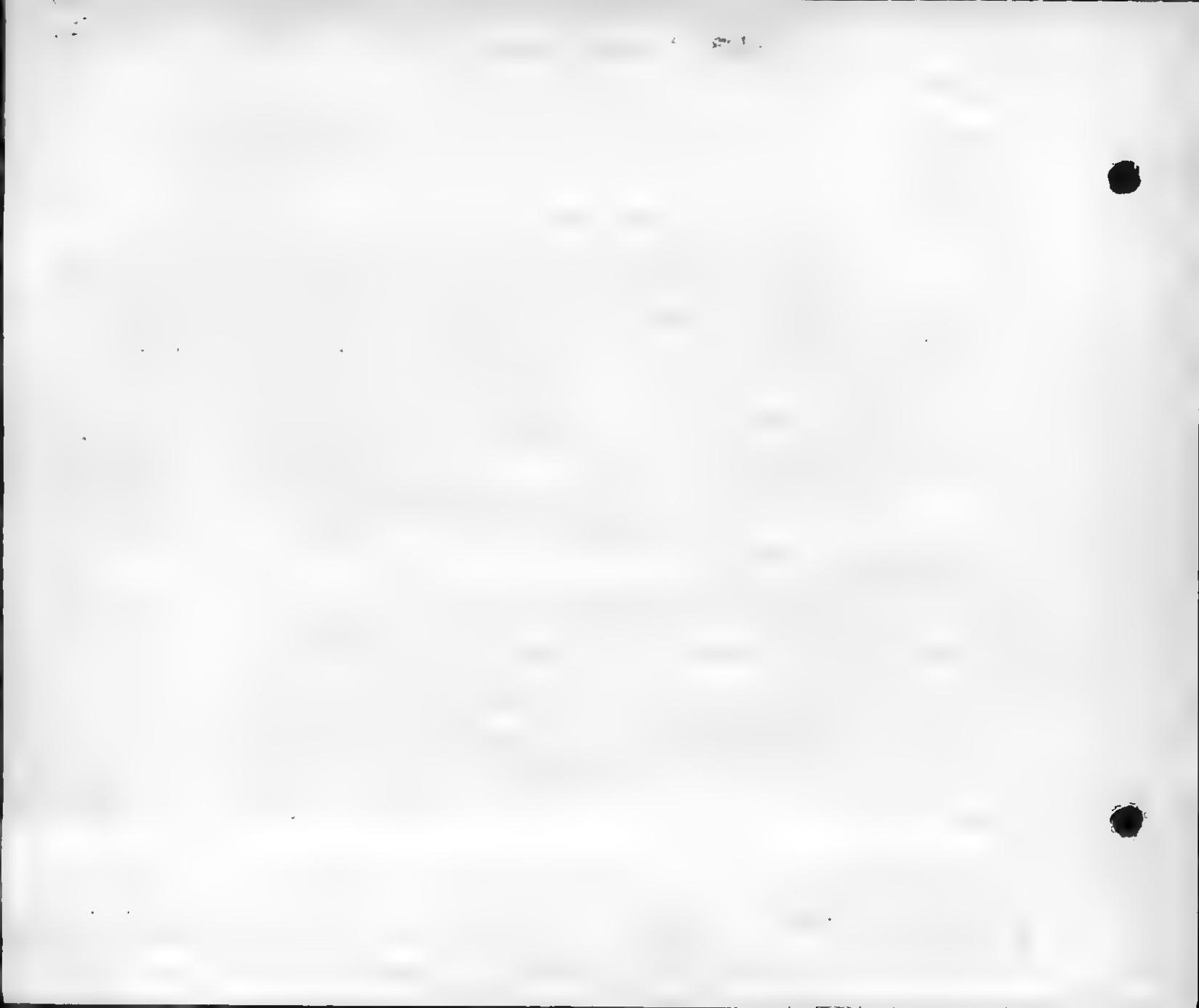


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11349 CERTIFICATE OF DEATH**

Reg. Dist. No.

11345

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia b. COUNTY Preston				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	c. LENGTH OF STAY IN 1b 4 mos 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Terra Alta ✓				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home		d. STREET ADDRESS Route # 2	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETTA	Middle LENORA	Last KELLY			
4. DATE OF DEATH October 13 1958.	Month	Day	Year			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 9 Days 28 Hours 0 Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Terra Alta, W.Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Silas Welch			14. MOTHER'S MAIDEN NAME Sarah Albright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Harry A. Kelly, Terra Alta, West Virginia.		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition &amp; general debility</i> DUE TO <i>General Paralysis</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 weeks</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Massive cerebral Hemorrhage &amp; brain softening - 2 yrs.</i> 4 mos (c) <i>Dehydration</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>April 14, 1956, to Oct 13, 1958</i> that I last saw the deceased alive on <i>Sept 1, 1958</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Chas E. Smith</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) CHAS. E. SMITH Terra Alta, W.Va. DATE SIGNED <i>10/14/58</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Centenary Cemetery		22d. LOCATION (City, town, or county) Centenary, Preston Co. W.Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reederson</i>			ADDRESS Terra Alta, W.Va.		24a. REC'D BY REGISTRAR Oct 15 '58	24b. REGISTRAR'S SIGNATURE <i>Chas E. Smith</i>

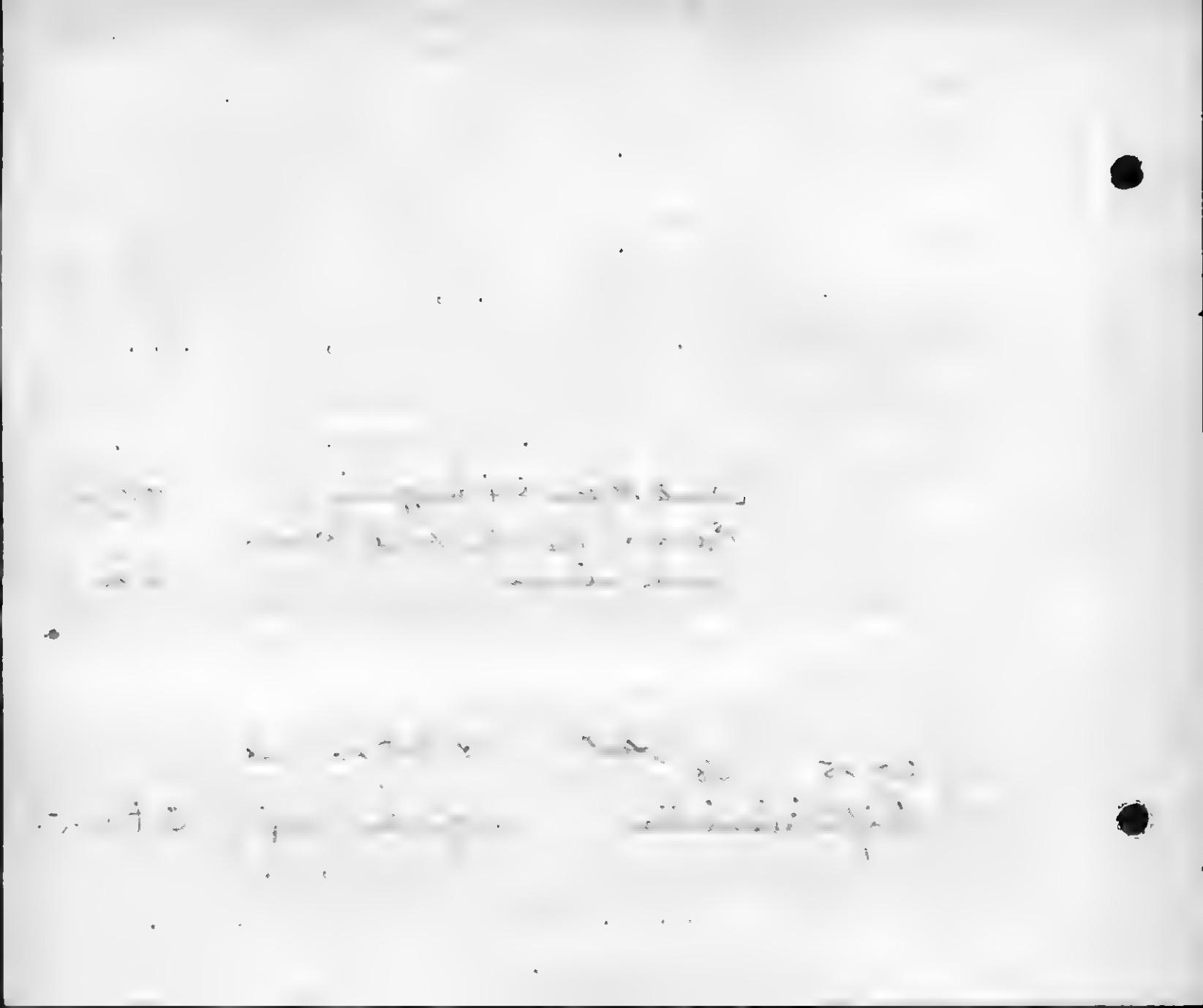


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11350 CERTIFICATE OF DEATH**

11346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional, give residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>		c. LENGTH OF STAY IN lb <b>9 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAIN STREET</b>		e. STREET ADDRESS <b>MAIN STREET</b>	
f. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>J OHN</b>	Middle <b>M.</b>	Last <b>McKEAN</b>
4. DATE OF DEATH	Month <b>OCTOBER</b>	Day <b>26</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 15, 1877</b>
9. AGE (In years (at birthday) yrs.) <b>81</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Merchandise Des Moines, Iowa</b>	11. BIRTHPLACE (State or foreign country) <b>Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>ROBERT McKEAN</b>	14. MOTHER'S MAIDEN NAME <b>JEANETTE McFADSON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>N ONE</b>	17. INFORMANT <b>Mrs. Minnie McKean, Kitzmiller, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
DUE TO  Due to  Due to  With edema		<i>Acute myocardial infarction Cardio - vascular fatal disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Sept 19 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 25, 1958</b> , to <b>Oct. 26, 1958</b> , that I last saw the deceased alive on <b>Oct. 25, 1958</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>Kitzmiller, Md.</b> DATE SIGNED <b>Oct. 27-58</b>	
ACTUAL SIGNATURE <b>Ralph Calandrella, M.D.</b>		PHYSICIAN'S NAME (Type) <b>RALPH CALANDRELLA, M.D.</b>	
22a. BURIAL, CREMATION, REBURIAL <b>BURIAL</b>		22b. DATE THEREOF <b>10/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>I.O.O.F. CEMETERY</b>		22d. LOCATION (City, town, or county) <b>ELK GARDEN, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Knighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 30 58</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Trahan</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11347

11351

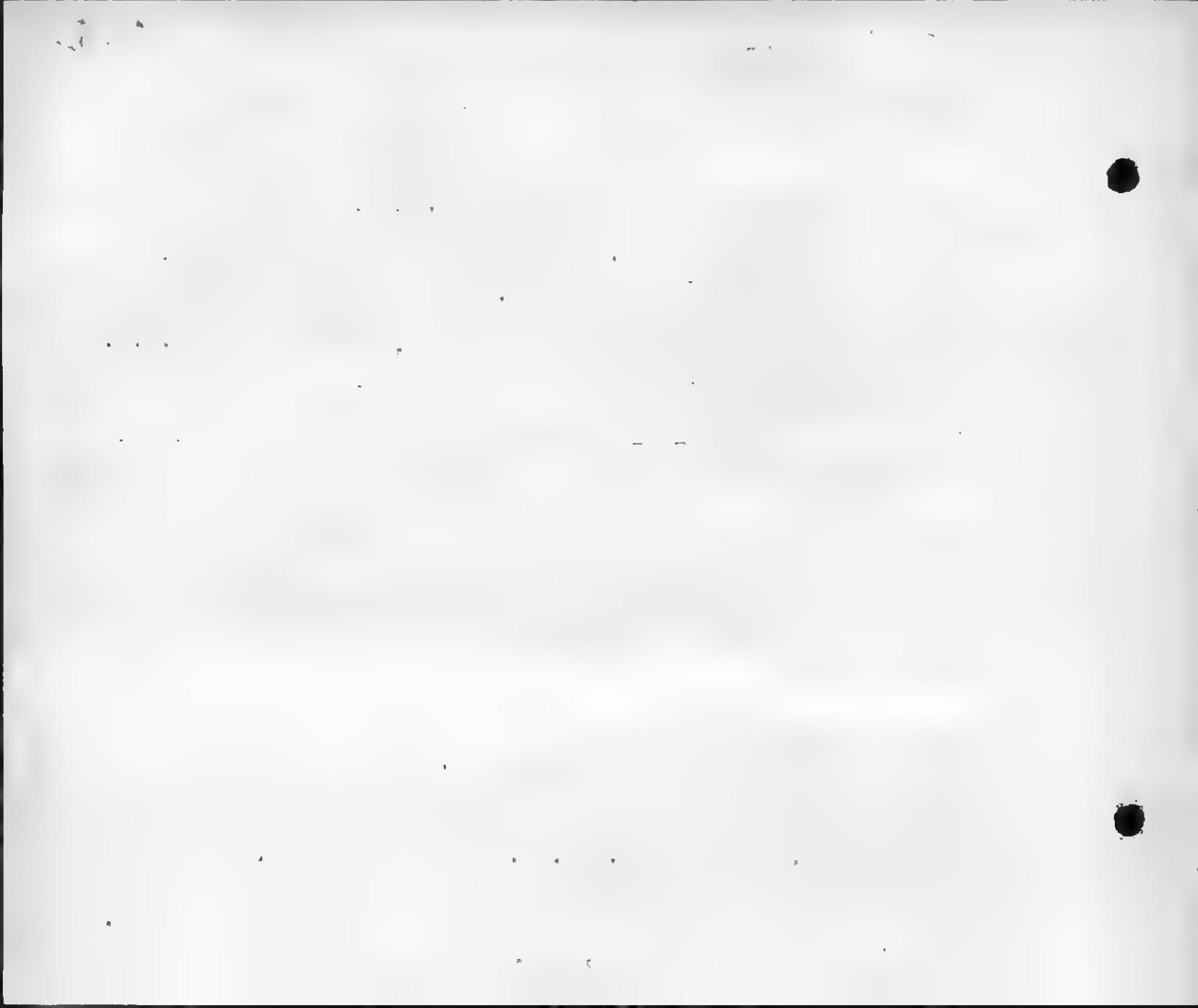
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS 52 W. Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle V.	Last Miller
4. DATE OF DEATH	Month October	Day 12,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines	11. BIRTHPLACE (State or foreign country) Avilton, Maryland
13. FATHER'S NAME Christopher Miller		14. MOTHER'S MAIDEN NAME Sarah Wiland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For men of unknown sex, if yes, give war or date of service) No	16. SOCIAL SECURITY NO 236-03-3984	17. INFORMANT Weeks Nursing Home	Address Oakland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maintain.</u> <u>an 40</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Lymphatic Leukemia, Chronic</u> DUE TO (c) <u>Arteriosclerotic Cardio - Renal Disease</u> Yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 10 1958</u> to <u>Oct 8 1958</u> , that I last saw the deceased alive on <u>Sept 8 1958</u> , and that death occurred at <u>9:10P</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>M.D. 58 2nd St. Oakland, Md.</u> DATE SIGNED <u>10-18-58</u>			
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.      Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/15/58	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn	ADDRESS Lonaconing, Md.	24a. REC'D BY REGISTRAR DATE OCT 15 '58	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 18&20 Film 234 10-14-58

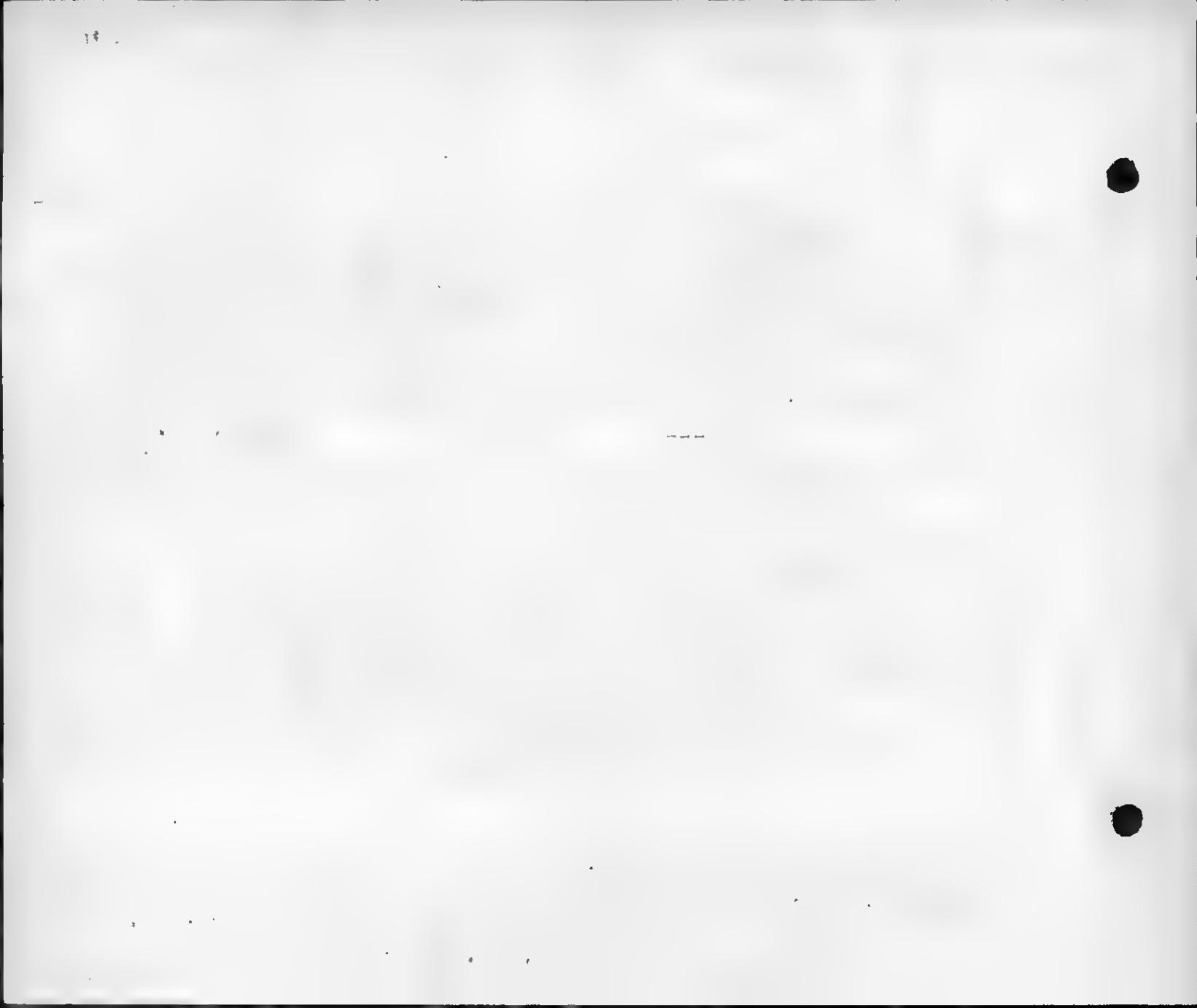
11348

11352

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUTTON</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>RUTH</b>	Middle	Last <b>MOON</b>	4. DATE OF DEATH <b>2/21/1871</b>	Month <b>OCTOBER</b>	Day <b>2</b>	Year <b>1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>2/21/1871</b>	AGE (In years last birthday) <b>80 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>0</b>	Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>MOON, GARRETT V.</b>		14. MOTHER'S MAIDEN NAME <b>WILSON, JANE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>BOYD HARDESTY</b>		Address <b>Hutton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Auto</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
44dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Arteriosclerosis</b> (c) <b>Infection at 2nd vert</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sin 1.47</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>Slipped on floor at home and fractured rt femur</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped on floor at home and fractured rt femur</b>					
20c. TIME OF INJURY Month, Day, Year Hour o m <b>11 a.m. 9-11-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hutton Garrett Md.</b>	
21. I certify that I attended the deceased from <b>Sat 11/1958</b> to <b>Cet 2, 1958</b> , that I last saw the deceased alive on <b>Cet 2, 1958</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>James H. Feaster, Jr. M.D.</b>						ADDRESS (Street, city or town, state) <b>58 21 St. Oakland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moon Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carrie S. Knoll</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

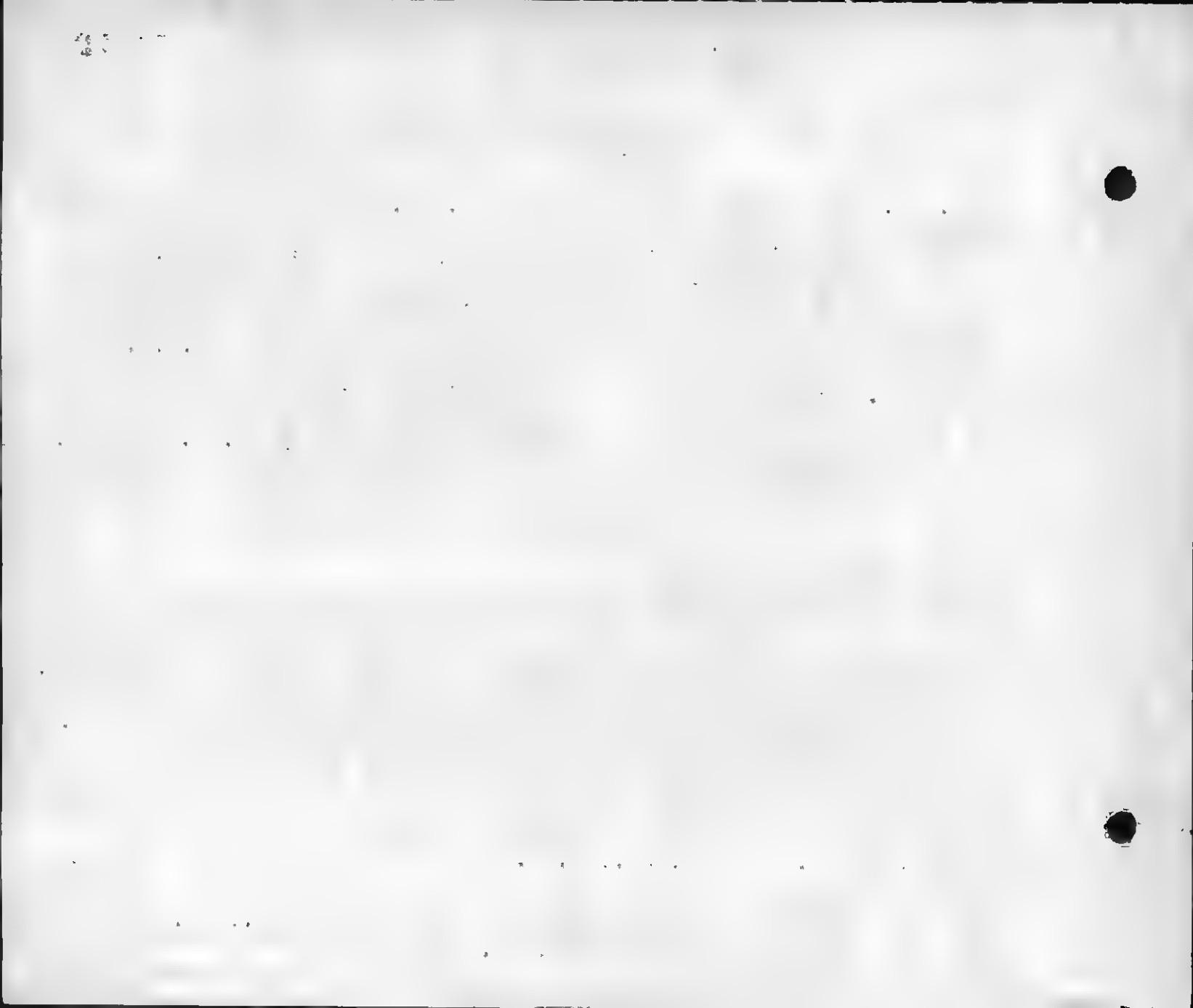
11349

Reg. Dist. No.

**11353**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMA3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
Garrett		Rural Oakland		traveling		a. STATE Maryland b. COUNTY Garrett					
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
						Rural Oakland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM?							
5 Mi. So. Oakland		5 Mi. So. Oakland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Daniel		William		Peachey	October	18,		1958			
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male		White	WIDOWED	DIVORCED	May 25, 1928	30 yrs.	Months Days	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Farmer			Own Farm			Pennsylvania			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Meno S. Peachey			Sadie Bender								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no						Lottie Lichty Peachey R. D. Oakland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken Neck									Immediate		
7121 DUE TO Crushed chest									II		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED?		
20a. EXTERNAL CAUSE WAS PR MARY OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm tractor upset and fell across neck and chest of deceased.							YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year 3:30 p.m. 10-18-58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) Unpaved Road		20f. (City or town) Rural Oakland		(County) Garrett		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		DATE SIGNED 10-19-58									
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (ACTING)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/1958		22c. NAME OF CEMETERY OR CREMATORIUM Slabaugh Cemetery		22d. LOCATION (City, town, or county) Garrett Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE OCT 21 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haase</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11350

## CERTIFICATE OF DEATH

M

Reg. Dist. No.

11354

1. PLACE OF DEATH o COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>		c. LENGTH OF STAY IN lb <b>2½ yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>William</b>		First	Middle	Lost	4. DATE OF DEATH <b>October 6,</b>	Month	Day	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1886</b>		9. AGE (In years b. birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during past 10 years of working life, even if retired) <b>Retired Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Church</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Samuel Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Martha Bishop</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>181-30-3554</b>		17. INFORMANT <b>Mrs. Wm. L. Phillips - Mt. Lake Park, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>				
42 d. 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		<i>Parkinson's Disease</i>		6-8 year				
(c) DUE TO		<i>Arteriosclerotic Cardio-Vascular Disease</i>		10-15 year				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Large Left Inguinal Hernia</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>July 1957</i> to <i>October 6, 1958</i> , that I last saw the deceased alive on <i>October 6, 1958</i> , and that death occurred at <i>10:00 P.M.</i> from the causes and on the date stated above								
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		ADDRESS (Street, city or town, State) <i>77 Oak St. Oakland, Md. 20058</i>		DATE SIGNED <i>10/6/58</i>				
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) <b>Oakland, Maryland.</b> (State)				
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>10/9/1958</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 9 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Charles J. Ross</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb Leighton</i>		ADDRESS <b>Oakland, Md.</b>						

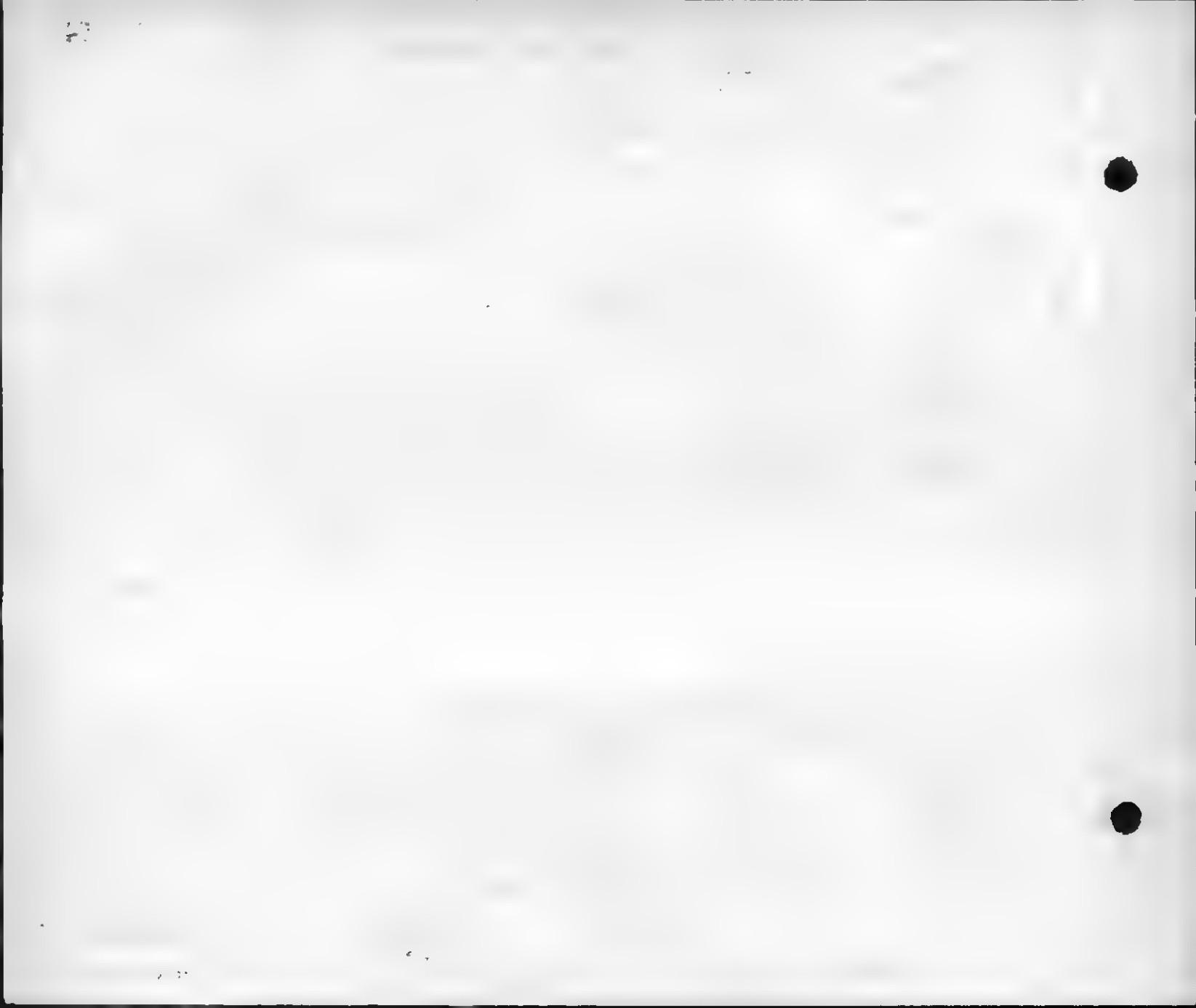


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11355 CERTIFICATE OF DEATH**

11351

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY  Garrett			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Longseneing		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Longseneing			d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First HAROLD		Middle WENDY		Last ROBESON		4. DATE OF DEATH Month October		Day 2	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1919			9. AGE (In years lost birthday) yrs. 88		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Formerly retired		10b. KIND OF BUSINESS OR INDUSTRY Fern work		11. BIRTHPLACE (State or foreign country) Avilton, Garrett Co., Md.			12. CITIZEN OF WHAT COUNTRY U.S.A.				
13. FATHER'S NAME John E. Robeson						14. MOTHER'S MAIDEN NAME Sara Michaels					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none			17. INFORMANT Ellis Robeson, Fros' b: 26, inc.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Heart block DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years 20 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Grantsville	20f. (City or town) Grantsville	(County) Garrett	(State) Md.		
21. I certify that I attended the deceased from Sept. 25, 1958, to Oct. 2, 1958, that I last saw the deceased alive on Oct. 1, 1958, and that death occurred at 11:15 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Grantsville, Md.		DATE SIGNED Oct 2, 1958			
ACTUAL SIGNATURE G. Pearce Attorney PHYSICIAN'S NAME (Type) FATCE 3P CIG											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 1, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion			22d. LOCATION (City, town, or county) Buried Grantsville, Garrett Co.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman		ADDRESS Grantsville, Md.					24a. REC'D BY REGISTRAR OCT 6 '58	24b. REGISTRAR'S SIGNATURE OCT 6 '58			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL <b>Mt. Lake Park,</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Garrett</b>
					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----					d. STREET ADDRESS -----	
					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>Allen</b>	Last <b>Sharpless</b>	4. DATE OF DEATH <b>October 8, 1958</b>	Month <b>October</b>	Day <b>8</b>	Year <b>1958</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1888</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>William Sharpless</b>	14. MOTHER'S MAIDEN NAME <b>Jane Davis</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>216-01-4866</b>	17. INFORMANT <b>Mrs. Robert Sharpless</b>	Address <b>Mt. Lake Park, Md.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Rupture of heart due to rifle shot.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) _____				
	DUE TO				
	(c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH					
Immediate					

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Suicide with foreign army rifle</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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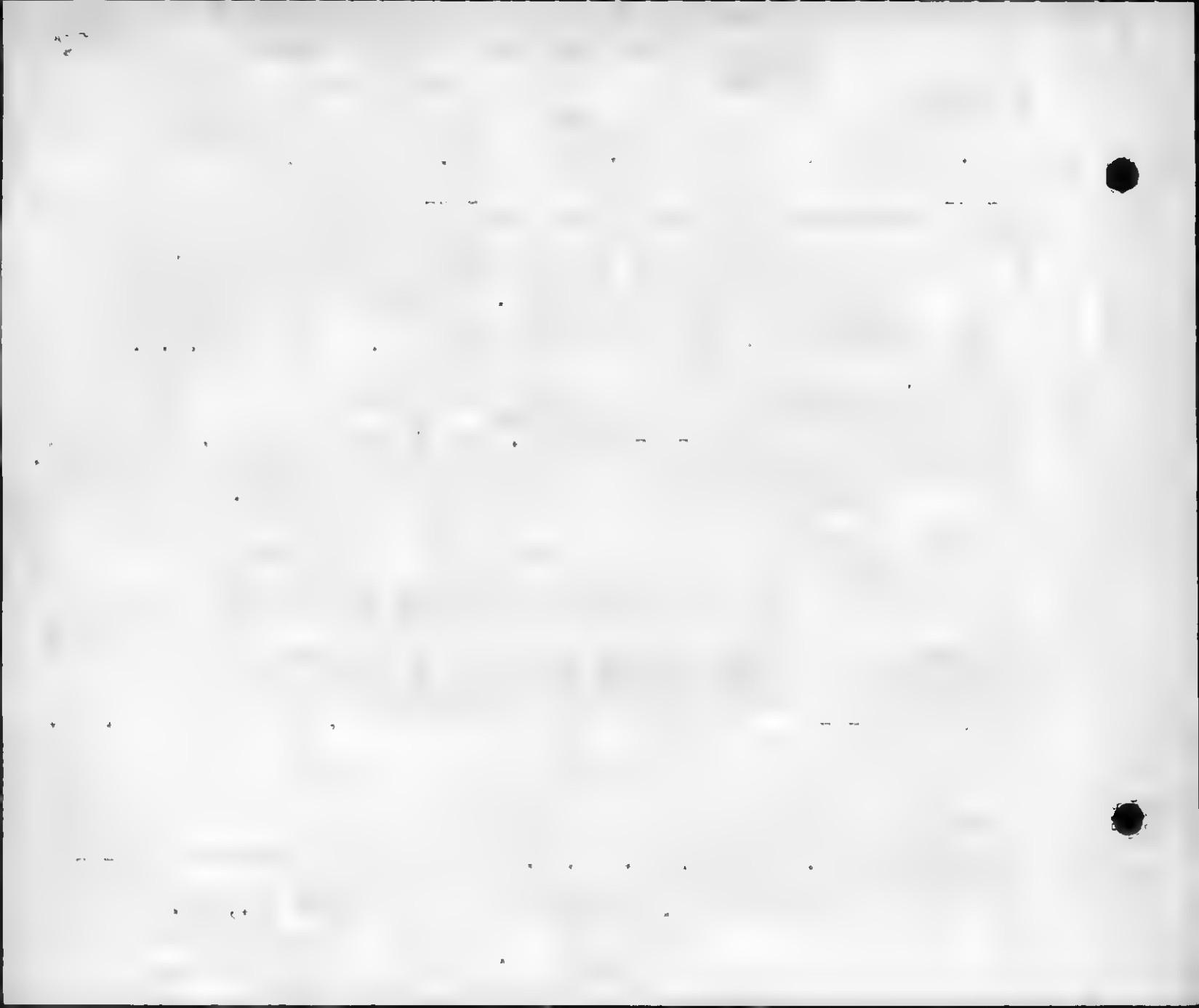
20c. TIME OF INJURY <b>3:30 p.m. 10-8-58</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, <b>HOME</b> street, office bldg., etc.)	20f. (City or town) <b>Mt. Lake Park Garr. Md.</b>	(County) <b>Garr.</b>	(State) <b>Md.</b>
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21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .
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ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <b>10-8-58</b>
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>	(ACTING)	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/11/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Zion Cemetery</b>	22d. LOCATION (City, town, or county) <b>Garrett Co., Md.</b>	(State) <b>Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>	ADDRESS <b>Oakland, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>OCT 14 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Robert S. Kraus</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11353

11357

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH o COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE W. Va. b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN lb 4 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kiser Nursing Home				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print)	First Murrian	Middle Washington	Last Smith	4. DATE OF DEATH Month October 19, Day 19 58	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 22, 1875	9. AGE (In years and birthday) 83 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Station Agent, Western Md.		10b. KIND OF BUSINESS OR INDUSTRY R. R., Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Harry Smith		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO ---		17. INFORMANT Howard D. Smith, 895 McMullen Highway Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral, Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arteriosclerosis, Cardio-vascular disease DUE TO (c) Senile,					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2, 1957 to 10-16, 1958, that I last saw the deceased alive on 10-16, 1958, and that death occurred at 7:00P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James H. Feaster, Jr., M. D. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) DATE SIGNED 10-21-58			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 10/22/1958		22b. DATE THEREOF 10/22/1958		22c. NAME OF CEMETERY OR CREMATORIUM Queens Point Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DAET 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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## INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 1-55 10A

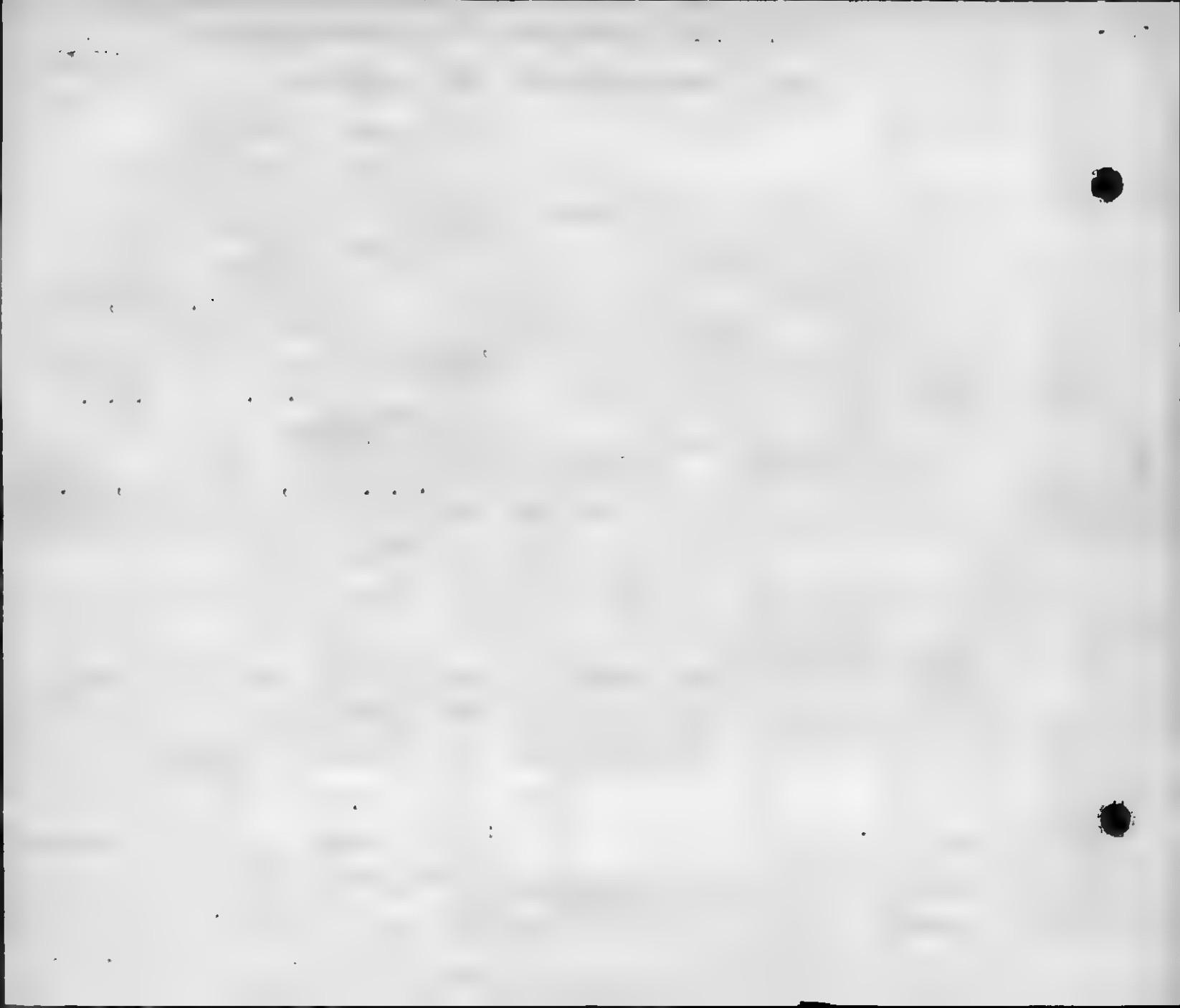
## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11358 CERTIFICATE OF DEATH

11354

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY GARRETT		MARYLAND	STATE MARYLAND		COUNTY GARRETT
CITY (If outside corporate limits, write RURAL OR endowments, towns) TOWN KITZMILLER		LENGTH OF STAY (In this place) <b>6 Weeks</b>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DEER PARK		
HOSPITAL OR INSTITUTION OR STREET ADDRESS  SPRING STREET		SUBDIVISION STREET ADDRESS  CHURCH STREET	(If rural give location)		
<b>3. NAME OF DECEASED</b> (First) MINNIE (Middle) ANNA (Last) TASKER			<b>4. DATE (Month) OF DEATH</b> OCT. 14, 1958 (Day) (Year)		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED	8. DATE OF BIRTH <b>MAY 25, 1883</b>	9. AGE last birthday <b>73</b> yrs.	IF UNDER 1 YEAR Months Deyas Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) W.V.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PETE HARDESTY			14. MOTHER'S MAIDEN NAME ANNA HARDESTY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no rank.) NO		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS MRS. D. V. PRATT, KITZMILLER, MD.	
<b>18. MEDICAL CERTIFICATION</b>					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <i>Bronchitis pneumonia</i></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</p>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from May 18th, 1956, to Oct. 11th, 1958, that I last saw the deceased alive on Oct. 11th, 1958, and that death occurred at 2:40 P.M. from the causes and on the date stated above.</p> <p>SIGNATURE <i>Lawrence Mance</i> M.D. ADDRESS (Street, city, town, state) <i>Oakland Md</i> DATE SIGNED <i>Nov 18</i></p>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/17/58		NAME OF CEMETERY OR CREMATORIUM DEER PARK CEMETERY	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Tasker</i>		LOCATION (City, town, or county) DEER PARK, MARYLAND	
DATE OCT 20 '58				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>H.C. Leighton</i> OAKLAND, MD.	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
11359 CERTIFICATE OF DEATH

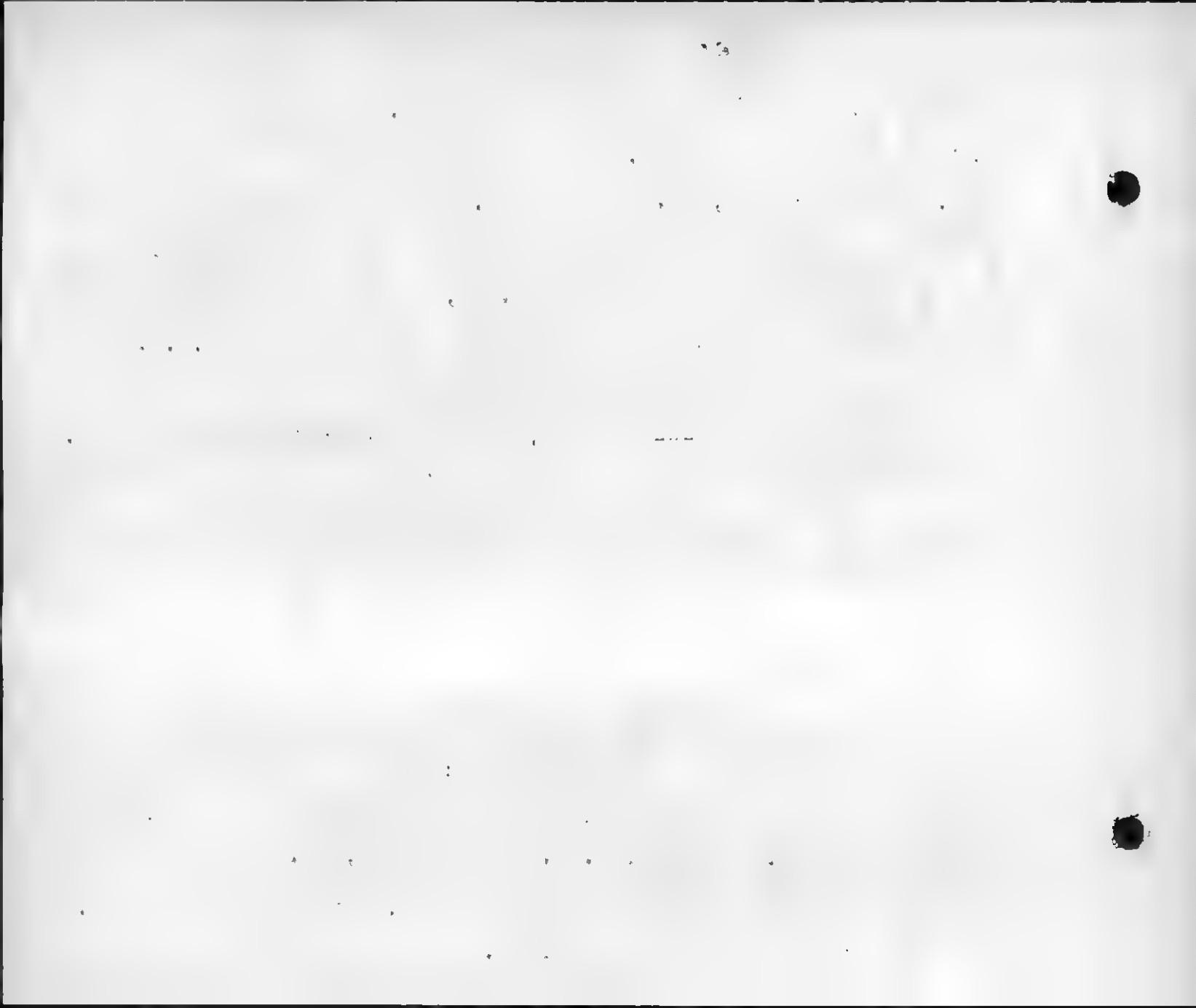
11355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>13 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>118 Oak Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Odessa</b>	First	Middle	Last	4. DATE OF DEATH <b>Turney</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1876</b>	9. AGE (in years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>George Beamer</b>				14. MOTHER'S MAIDEN NAME <b>Melissa Dxxxxx True</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Paul A. Turney, Oakland, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		DUE TO <b>Atherosclerosis</b>		(c)		<b>10 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>30 act, 1958, in 31 act, 49</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 act, 1958, to 31 act, 49</b> , that I last saw the deceased alive on <b>31 act, 1958</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. Mance</b>				ADDRESS (Street, city or town, state) <b>Oakland, Md.</b> DATE SIGNED <b>3/act/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Andrew E. Mance</b>		Oakland, Maryland					
22a. BURIAL CREMATION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/2/1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Oakland Cemetery</b>		22d. LOCATION (City, town or county) <b>Oakland, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. L. Lington</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>50</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Wm. L. Farmer</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 11356
11360 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park c. LENGTH OF STAY IN 1b 8 yrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Mi. West Deer Park, Md.					d. STREET ADDRESS 1 Mi. West Deer Park					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Effie	Middle Myrtle	Last Uphold	4. DATE OF DEATH Month October 18, 1958	Day	Year			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 12, 1873	9. AGE (In years at birthday) 88 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Teets					14. MOTHER'S MAIDEN NAME Esther Gutherie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tax no or unknown) no			16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Theodore Reckart		Address Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction 12 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardiovascular Disease Unknown (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from September 1958 to October 1958, that I last saw the deceased alive on Oct. 17, 1958, and that death occurred at 2:45A M, from the causes and on the date stated above										
ACTUAL <i>Herbert H. Leighton, M.D.</i> PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. ADDRESS (Street, city or town, state) 77 Oak St, Oakland, Md. DATE SIGNED 10/21/58										
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial, 10/20/1958		22b. DATE THEREOF 10/20/1958			22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose Cemetery, near Friendsville, Md.			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>		ADDRESS Oakland, Md.			24a. REC'D BY REGISTRAR DATE OCT 21 '58			24b. REGISTRAR'S SIGNATURE <i>C. H. S. Trahan</i>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11361 CERTIFICATE OF DEATH										Reg. Dist. No. 11357
<b>1. PLACE OF DEATH</b> a. COUNTY GARRETT MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL					<b>2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)</b> a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SWANTON X d. STREET ADDRESS North Glade / e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED (Type or print)</b> First MARY Middle ELLEN Last WEIMER				<b>4. DATE OF DEATH</b> Month OCTOBER Day 12 Year 1958						
<b>5. SEX</b> FEMALE		<b>6. COLOR OR RACE</b> W WIDOWED D DIVORCED		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> SEPT. 16, 1875		<b>9. AGE (In years last birthday)</b> 83 yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) HOUSEWIFE			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Own Home			<b>11. BIRTHPLACE (State or foreign country)</b> MARYLAND			<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> JOSEPH R. GLASS					<b>14. MOTHER'S MAIDEN NAME</b> MAX SWEITZER, Caroline					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> --- --- ---			<b>17. INFORMANT</b> MRS. EARL BECKMAN			Address R. # 2 - SWANTON, MD.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> 420.0 DUE TO <i>Atherosclerosis heart disease 6 months</i> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (b) _____ DUE TO _____ (c) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) OAKLAND		<b>20f. (City or town)</b> (County) MARYLAND (State)			
<b>21. I certify that I attended the deceased from</b> Aug. 13th, 1958 <b>to</b> Oct. 12th, 1958 <b>that I last saw the deceased alive on</b> Oct. 12th, 1958 <b>and that death occurred at</b> 2:15 P.M. <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <i>Andrew E. Mance, M.D.</i> <b>ADDRESS (Street, city or town, state)</b> <i>Oakland, Md.</i> <b>DATE SIGNED</b> <i>13 Oct 58</i>										
<b>PHYSICIAN'S NAME (Type)</b> ANDREW E. MANCE, M.D.		<b>OAKLAND</b> <b>MARYLAND</b>								
<b>22a. BURIAL, CREMATION, ETC. (Specify)</b> Burial		<b>22b. DATE THEREOF</b> 10/15/1958		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> George Cemetery		<b>22d. LOCATION (City, town, or county)</b> near Swanton, Md.				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>H. Legerton</i>		<b>ADDRESS</b> Oakland, Md.		<b>24a. REC'D BY REGISTRAR</b> DATE OCT 17 '58		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Carter S. Kline</i>				

CONFIDENTIAL - SECURITY INFORMATION - DRAFT

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11362

## CERTIFICATE OF DEATH

11358

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EMORYVILLE</b> <b>85X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT C. WILSON</b>		First	Middle	Lost	4. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>1958</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12/26/1879</b>	9. AGE (In years lost birthday) <b>78</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>FAUSTINE WILSON</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE MARGERTUM</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-26-3710</b>		17. INFORMANT <b>HARRY WILSON</b>	
				Address <b>EMORYVILLE, W. VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Bronchitis pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Cerebral hemorrhage</b> 5 days (c) <b>Arterosclerosis</b> 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 6th, 1958</b> , to <b>Oct. 11th, 1958</b> , that I last saw the deceased alive on <b>Oct. 11th, 1958</b> , and that death occurred at <b>8:10P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Andrew E. Mance</i>		ADDRESS (Street, city or town, state) <b>Oakland Md.</b> DATE SIGNED <b>12 Oct 58</b>			
PHYSICIAN'S NAME (Type) <b>DR. ANDREW E. MANCE</b>					
22a. BURIAL, CREMATION, BURIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/14/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Nethkin Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Elk Garden, W. Va.</b>		(State) <b>W. Va.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 17 58</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>St. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Orville S. Kraus</i>	

